

		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038349</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Heritage Manor-Bloomington</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>	
Address: <u>700 East Walnut</u> <u>Bloomington</u> <u>61701</u>			
<div>NumberCityZip Code</div>			
County: <u>McLean</u>			
Telephone Number: <u>(309) 827-8004</u> Fax # <u>()</u>			
HFS ID Number: <u>370909086003</u>		<div>Officer or Administrator of Provider</div> <div>(Signed) _____ (Date) _____</div> <div>(Type or Print Name) <u>Craig L. Ater</u></div> <div>(Title) <u>Senior V.P. & CFO</u></div> <div>Paid Preparer</div> <div>(Print Name and Title) _____</div> <div>(Firm Name & Address) _____</div> <div>(Telephone) <u>()</u> Fax # <u>()</u></div> <div>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>	
Date of Initial License for Current Owners: <u>1963</u>			
Type of Ownership:			
<div><div><input type="checkbox"/> VOLUNTARY,NON-PROFIT</div><div><input type="checkbox"/> Charitable Corp.</div><div><input type="checkbox"/> Trust</div><div>IRS Exemption Code _____</div></div> <div><div><input checked="" type="checkbox"/> PROPRIETARY</div><div><input type="checkbox"/> Individual</div><div><input type="checkbox"/> Partnership</div><div><input type="checkbox"/> Corporation</div><div><input checked="" type="checkbox"/> "Sub-S" Corp.</div><div><input type="checkbox"/> Limited Liability Co.</div><div><input type="checkbox"/> Trust</div><div><input type="checkbox"/> Other _____</div></div> <div><div><input type="checkbox"/> GOVERNMENTAL</div><div><input type="checkbox"/> State</div><div><input type="checkbox"/> County</div><div><input type="checkbox"/> Other _____</div></div>			

#	0038349	Report Period Beginning:	01/01/05	Ending:	12/31/05
---	---------	--------------------------	----------	---------	----------

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census?

YES ☐ NO ☒

YES ☐ NO ☒

Date started 1963

YES ☐ Date _____ NO ☒ **XX**

YES NO If YES, enter number
of beds certified _____ and days of care provided 5,117

Medicare Intermediary Mutual of Omaha

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
	xx	CASH*			

Is your fiscal year identical to your tax year? YES ☐ NO ☐

*** All facilities other than governmental must report on the accrual basis.**

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,125	11,239	5,117	35,481	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	19,125	11,239	5,117	35,481	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **87.57%**

*** All facilities other than governmental must report on the accrual basis.**

Facility Name & ID Number Heritage Manor-Bloomington # 0038349 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	216,875	24,905		241,780		241,780	4,899	246,679			1
2	Food Purchase		175,860		175,860		175,860		175,860			2
3	Housekeeping	76,776	16,797		93,573		93,573	5	93,578			3
4	Laundry	65,324	14,599		79,923		79,923		79,923			4
5	Heat and Other Utilities			121,097	121,097		121,097	1,546	122,643			5
6	Maintenance	103,236	53,572	41,339	198,147		198,147	12,958	211,105			6
7	Other (specify):*											7
8	TOTAL General Services	462,211	285,733	162,436	910,380		910,380	19,408	929,788			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,591,794	145,257	125,045	1,862,096		1,862,096		1,862,096			10
10a	Therapy		353,217	619,555	972,772	(507,570)	465,202	114,184	579,386			10a
11	Activities	52,473	2,259		54,732		54,732		54,732			11
12	Social Services	46,862	72	2,509	49,443		49,443		49,443			12
13	CNA Training	10,744	(2,550)		8,194		8,194	1,741	9,935			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,701,873	498,255	759,109	2,959,237	(507,570)	2,451,667	115,925	2,567,592			16
	C. General Administration											
17	Administrative	59,000			59,000		59,000	75,117	134,117			17
18	Directors Fees							5,576	5,576			18
19	Professional Services			343,163	343,163		343,163	(327,669)	15,494			19
20	Dues, Fees, Subscriptions & Promotions			107,192	107,192	(60,773)	46,419	(16,093)	30,326			20
21	Clerical & General Office Expenses	122,705	15,087	15,148	152,940		152,940	155,048	307,988			21
22	Employee Benefits & Payroll Taxes			452,948	452,948		452,948	40,355	493,303			22
23	Inservice Training & Education			692	692		692	1,307	1,999			23
24	Travel and Seminar			4,337	4,337		4,337	(2,338)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,148	78,148		78,148	1,979	80,127			26
27	Other (specify):*			51,096	51,096		51,096	(51,000)	96			27
28	TOTAL General Administration	181,705	15,087	1,052,724	1,249,516	(60,773)	1,188,743	(117,718)	1,071,025			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,345,789	799,075	1,974,269	5,119,133	(568,343)	4,550,790	17,615	4,568,405			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			149,305	149,305		149,305	13,149	162,454			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,414	125,414		125,414	22,734	148,148			32
33	Real Estate Taxes			76,294	76,294		76,294		76,294			33
34	Rent-Facility & Grounds							671	671			34
35	Rent-Equipment & Vehicles			3,639	3,639		3,639	1,010	4,649			35
36	Other (specify):*											36
37	TOTAL Ownership			354,652	354,652		354,652	37,564	392,216			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					507,570	507,570		507,570			39
40	Barber and Beauty Shops			15,582	15,582		15,582		15,582			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,773	60,773		60,773			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			15,582	15,582	568,343	583,925		583,925			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,345,789	799,075	2,344,503	5,489,367		5,489,367	55,179	5,544,546			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(694)	35		5
6	Rented Facility Space	(6,120)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(158)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(528)	20		17
18	Fines and Penalties				18
19	Entertainment	(12,673)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,935)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,000)	27		24
25	Fund Raising, Advertising and Promotional	(20,280)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		23		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (96,388)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	151,567		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 151,567		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 55,179		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(694)	35
6		(6,120)	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(528)	20
18			18
19			24
20		0	27
21			21
22		(4,935)	19
23			23
24		(51,000)	27
25		(20,280)	20
26			26
27			27
28			28
29		0	23
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(83,557)	49

Summary A

12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	338,228	Heritage Enterprises, Inc.	100.00%		(338,228)	4
5	V								5
6	V	10a	Adjustment for Related Organization	350,840	GreenTree Pharmacy	100.00%	465,024	114,184	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 689,068			\$ 465,024	\$ * (224,044)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 4,899	\$ 4,899	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				5	5	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,546	1,546	19
20	V	6	Maintenance				12,958	12,958	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,741	1,741	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				75,117	75,117	29
30	V	18	Directors Fees				5,576	5,576	30
31	V	19	Professional Services				15,494	15,494	31
32	V	20	Fees, Subscription, Promotions				4,715	4,715	32
33	V	21	Clerical & General Office Expenses				155,048	155,048	33
34	V	22	Employee Benefits & Payroll Taxes				40,355	40,355	34
35	V	23	Inservice Training & Education				1,307	1,307	35
36	V	24	Travel and Seminar				10,335	10,335	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,979	1,979	38
39	Total			\$			\$ 331,075	\$ * 331,075	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$	0	15
16	V	30	Depreciation					13,149	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					22,892	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,791	20
21	V	35	Rent-Equipment & Vehicles					1,704	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	0	\$ * 44,536 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Bloomington # 0038349 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	\$ 16,950	Ln 17&18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17&18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	19,008	Ln 17&18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	11,318	Ln 17&18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	14,750	Ln 17&18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	7,278	Ln 17&18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	8,157	Ln 17&18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	3,232	Ln 17&18	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 80,693		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor-Bloomington# 0038349

Report Period Beginning:

01/01/05Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Heritage Enterprises

Street Address

115 W. Jefferson

City / State / Zip Code

Bloomington,IL

Phone Number

()

Fax Number

()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	\$ 115,289	\$ 115,276	111	\$ 4,899	1
2	2	Food Purchase	Beds	2,612	25	7	0	111	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	111	5	3
4	4	Laundry	Beds	2,612	25	0	0	111	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	111	1,546	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	111	12,958	6
7	7	Other	Beds	2,612	25	0	0	111	0	7
8	9	Medical Director	Beds	2,612	25	0	0	111	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	111	0	9
10	11	Activities	Beds	2,612	25	0	0	111	0	10
11	12	Social Service	Beds	2,612	25	0	0	111	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	111	1,741	12
13	14	Program Transportation	Beds	2,612	25	0	0	111	0	13
14	15	Other	Beds	2,612	25	0	0	111	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	111	75,117	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	111	5,576	16
17	19	Professional Services	Beds	2,612	25	364,592	0	111	15,494	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	111	4,715	18
19	21	Clerical & General Office Expense	Beds	2,612	25	3,648,522	3,309,912	111	155,048	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,612	25	949,625	0	111	40,355	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	111	1,307	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	111	10,335	22
23	25	Other Admin. Staff Transportation	Beds	2,612	25	0	0	111	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	111	1,979	24
25	TOTALS					\$ 7,790,758	\$ 5,312,885		\$ 331,075	25

Facility Name & ID Number Heritage Manor-Bloomington # 0038349 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	\$	\$	111	\$	1
2	30	Depreciation	Beds	2,612	25	309,426		111	13,149	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			111		3
4	32	Interest	Beds	2,612	25	538,695		111	22,892	4
5	33	Real Estate Taxes	Beds	2,612	25			111		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		111	6,791	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		111	1,704	7
8	36	Other	Beds	2,612	25			111		8
9	38	Medically Nec Transportation	Beds	2,612	25			111		9
10	39	Ancillary Service Centers	Beds	2,612	25			111		10
11	40	Barber and Beauty Shops	Beds	2,612	25			111		11
12	41	Coffee and Gift Shops	Beds	2,612	25			111		12
13	42	Other	Beds	2,612	25			111		13
14								111		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,048,023	\$		\$ 44,536	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$	\$ 1,794,557	01/15/06	variable	\$ 101,184	1	
2	LsSalle National Bank		xx	Mortgage							5,534	2	
3												3	
4												4	
5												5	
	Working Capital												
6	LsSalle National Bank		xx	Working Capital							18,696	6	
7	LsSalle National Bank		xx									7	
8												8	
9	TOTAL Facility Related						\$	\$ 1,794,557			\$ 125,414	9	
	B. Non-Facility Related*												
10	Interest Income										(158)	10	
11	Allocated Corporate										22,892	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 22,734	14	
15	TOTALS (line 9+line14)						\$	\$ 1,794,557			\$ 148,148	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>	\$	72,337	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	72,503	2
3. Under or (over) accrual (line 2 minus line 1).			\$	166	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	76,128	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	76,294	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000		8	
		2001		9	
		2002		10	
		2003		11	
		2004		12	
				FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0038349

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	21-04-227-012	Heritage Manor-Bloomington	\$ 72,503.00	\$ 72,503.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 72,503.00	\$ 72,503.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,183 B. General Construction Type: Exterior Wood/Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 116,576	1
2					2
3	TOTALS			\$ 116,576	3

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	111				\$560,548	\$		\$	\$	\$	4
5					221,147						5
6											6
7											7
8											8
	Improvement Type**										
9	1978 Improvements			1978	14,607						9
10	1979 Improvements			1979	95,460						10
11	1980 Improvements			1980	75,591						11
12	1981 Improvements			1981	11,544						12
13	1982 Improvements			1982	9,256						13
14	1983 Improvements			1983	13,130						14
15	1984 Improvements			1984	7,215						15
16	1985 Improvements			1985	45,885						16
17	1986 Improvements			1986	13,469						17
18	1988 Improvements			1988	83,109						18
19	1989 Improvements			1989	2,439						19
20	1990 Improvements			1990	30,676						20
21	1991 Improvements			1991	4,207						21
22	1992 Improvements			1992	1,208						22
23	1993 Improvements			1993	97,303						23
24	1994 Improvements			1994	29,638						24
25	1995 Improvements			1995	121,304						25
26	BOILER			1996	17,850						26
27	EXHAUST HOOD			1996	1,075						27
28	CODE ALERT			1996	1,852						28
29	PHONE SYSTEM			1996	2,339						29
30	INTERIOR REMODEL			1996	103,103						30
31											31
32											32
33											33
34	C/O Allocation							13,149	13,149		34
35	Book Depreciation					123,401		123,401		1,202,770	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Interior Rehab--paint, wallpaper, remodel facility	1997	\$211,945	\$		\$	\$	\$	37
38	Remodel Physical Therapy	1997	43,069						38
39	Disposal Unit--Kitchen	1997	1,439						39
40	Code Alert System	1997	1,997						40
41	Kitchen Remodel	1997	766						41
42									42
43	Code Alert/Nurse Call System	1998	3,654						43
44	Kitchen Remodel	1998	4,166						44
45	Remodel Physical Therapy	1998	1,813						45
46	Addition--Materials	1998	13,431						46
47	Addition--Professional Fees	1998	109,885						47
48									48
49	Addition--Materials	1999	1,155,066						49
50	Addition--Professional Fees	1999	22,035						50
51	Steam Table Hood	1999	3,821						51
52	ALTA Survey	1999	2,434						52
53	Dish Washing Area	1999	4,083						53
54	Sewage Pump	1999	2,492						54
55	Parking Lot Pavement	1999	6,743						55
56									56
57	Dayroom Light Fixtures	2000	6,189						57
58	Door Kickplates	2000	2,991						58
59	Storm windows	2000	4,011						59
60	Addition--Materials	2000	12,770						60
61	Addition--Professional Fees	2000	5,893						61
62	Roof Repair	2000	5,510						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$3,190,158	\$123,401		\$136,550	\$13,149	\$1,202,770	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$3,190,158	\$123,401		\$136,550	\$13,149	\$1,202,770	1
2	Paging System	2001	2,456						2
3	Alarm Door/Lock	2001	1,950						3
4	Code Alert	2001	3,965						4
5	Electrical Wiring for A/C Unit	2001	1,805						5
6	Main Water Meter	2001	2,000						6
7	Valves Boiler Unit	2001	1,883						7
8									8
9	Smoke Detectors and Installation	2002	14,551						9
10	Mixing valve	2002	1,862						10
11	Main Corridor Rehab (Wallcovering)	2002	3,885						11
12	Floor Tile	2002	1,280						12
13	Kitchen	2002	957						13
14	Roof Repair	2002	5,283						14
15									15
16	Smoke Detectors and Installation	2003	5,970						16
17	Roof Replacement	2003	111,250						17
18	Sprinklers	2003	31,119						18
19	Parking Lot	2003	3,862						19
20	Ceramic Tile	2003	1,315						20
21	Compressor	2003	3,898						21
22	Wallpaper	2003	857						22
23	Maglock Keypad	2003	2,762						23
24	ANSUL Fire Surpression	2003	1,450						24
25	Fire Escape Remodel	2003	2,003						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,396,521	\$123,401		\$136,550	\$13,149	\$1,202,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$3,396,521	\$123,401		\$136,550	\$13,149	\$1,202,770	1
2									2
3	Sewage Pump	2004	3,823						3
4	Nurses Station A/C	2004	1,478						4
5	Fire Alarm	2004	2,825						5
6	Sealcoat Parking Lot	2004	1,646						6
7	Storm Windows	2004	645						7
8	Window A/C (8)	2004	6,030						8
9	Ceiling Repairs	2004	4,011						9
10									10
11	Delayed Egress Latches	2005	12,431						11
12	Mixing valve		1,360						12
13	Paint ceiling		596						13
14	A/C		2,153						14
15	Sidewalk		2,100						15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,435,619	\$123,401		\$136,550	\$13,149	\$1,202,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,039,668	\$25,904	\$25,904	\$		\$934,762	71
72	Current Year Purchases	20,547						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,060,215	\$25,904	\$25,904	\$		\$934,762	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,612,410	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$149,305	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$162,454	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$13,149	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,137,532	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 4,649
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA _____
		HOURS PER CNA _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		(2,550)		(2,550)
3	Classroom Wages (a)		10,744		10,744
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,194	\$	\$ 8,194
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,194			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 233,978	\$		\$ 233,978	1
2	Licensed Speech and Language Development Therapist		hrs			23,554			23,554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			321,145	709		321,854	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				466,692		466,692	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					40,878			40,878	13
14	TOTAL			\$		\$ 619,555	\$ 467,401		\$ 1,086,956	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$400	\$	1
2	Cash-Patient Deposits	9,492		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	734,975		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,612		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	599,293		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,362,772	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,576		13
14	Buildings, at Historical Cost	3,377,700		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,028,594		16
17	Accumulated Depreciation (book methods)	(2,137,532)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$2,385,338	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$3,748,110	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$96,048	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,492		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	237,703		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,028		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,128		32
33	Accrued Interest Payable	7,975		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$430,374	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,794,557		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$1,794,557	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$2,224,931	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$1,523,179	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$3,748,110	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,428,858	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,428,858	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	94,321	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 94,321	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,523,179	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,270,354	1
2	Discounts and Allowances for all Levels	(1,690,922)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,579,432	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,424,112	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,424,112	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	383	12
13	Barber and Beauty Care	22,064	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,120	16
17	Sale of Drugs	553,749	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 582,326	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	158	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 158	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,586,028	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	910,380	31
32	Health Care	2,959,237	32
33	General Administration	1,249,516	33
	B. Capital Expense		
34	Ownership	354,652	34
	C. Ancillary Expense		
35	Special Cost Centers	15,582	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		2,340	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,491,707	40
41	Income before Income Taxes (line 30 minus line 40)**	94,321	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 94,321	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,936	2,267	\$ 51,191	\$ 22.58	1
2	Assistant Director of Nursing	1,380	1,520	29,027	19.10	2
3	Registered Nurses	9,687	10,371	205,706	19.83	3
4	Licensed Practical Nurses	23,540	25,484	491,304	19.28	4
5	CNAs & Orderlies	73,141	76,993	780,170	10.13	5
6	CNA Trainees	1,100	1,100	10,744	9.77	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,248	2,481	34,396	13.86	8
9	Activity Director					9
10	Activity Assistants	5,542	5,856	52,473	8.96	10
11	Social Service Workers	3,693	4,279	46,862	10.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,267	21,026	216,875	10.31	15
16	Dishwashers					16
17	Maintenance Workers	9,060	9,719	103,236	10.62	17
18	Housekeepers	9,895	10,408	76,776	7.38	18
19	Laundry	6,105	6,842	65,324	9.55	19
20	Administrator	1,900	2,080	59,000	28.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,788	9,851	122,705	12.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,282	190,277	\$ 2,345,789 *	\$ 12.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		1,800		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,982		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,509		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,291		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	148	\$ 4,432		50
51	Licensed Practical Nurses	2,122	53,057		51
52	Certified Nurse Assistants/Aides	2,737	54,735		52
53	TOTAL (lines 50 - 52)	5,007	\$ 112,224		53

(See instructions.)

[illegible]

Facility Name & ID Number Heritage Manor-Bloomington

0038349

Report Period Beginning: 01/01/05

Ending: 12/31/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,773
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 723
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

[illegible]

(NET INCOME)

					2,612	111	3,471,750	71,391,262	
Name	Title	Function	Total Pay	usted by Mgmt F	Total # Beds	Facility # Beds	Jon-Nursing Hom	Nursing Home	This Facility
### Susie Jefferson	Director	Management	418,245	418,245			19,396	398,849	16,950
### Tom Jefferson	Secretary	Management	0	0			0	0	0
### Craig Hart	Chairman	Management	469,049	469,049			21,752	447,297	19,008
### Cheryl Lowney	Executive Vice Presic	Management	279,290	279,290			12,952	266,338	11,318
### Steve Wannemache	President	Management	363,969	363,969			16,879	347,090	14,750
### Connie Hoselton	Sr Vice President	Management	179,584	179,584			8,328	171,256	7,278
### Craig Ater	Sr Vice President	Management	201,279	201,279			9,334	191,945	8,157
Ben Hart			79,758	79,758			3,699	76,059	3,232
13			1,991,174	1,991,174				1,898,834	80,693

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the homes(s) as well as the amount paid. This amount must agree 0 5,571,251 total salaries
1,991,174

**This must include all forms of compensation paid by related entities and allocated to Schedule V o 0 total mgt fees
PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND
MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.